REQUEST FOR PRIOR AUTHORIZATION FOR HOME MODIFICATIONS AND/OR SPECIAL MEDICAL EQUIPMENT

MID: _____ Date of Assessment: _____

Name:_____

Address: _____

DOB: _____ Weight: _____ Height: _____

Physician's Name/RNP: _____

Diagnosis/Medical Condition: _____

Property: Owned/Family Owned or Rented (circle one). If rental, include form GW-RA.

Equipment currently utilized for mobility (check all that apply):

☐ Manual wheelchair ☐ Power wheelchair ☐ Scooter ☐ Walker ☐ Cane ☐ None

1. Functional Presentation:

_____
_____
_____
_____
_____
_____
_____
_____

2. Requested Equipment/Accessories:

_____
_____
_____
_____

3. Is this equipment replacing a similar piece of equipment? If yes, please justify why the existing equipment does not meet the recipient's needs:

_____
_____
_____
_____
_____

4. What other equipment has been considered before deciding on this equipment?

_____

_____

_____

5. Please explain why this equipment is necessary:

_____

_____

_____

_____

_____

_____

6. Is the requested equipment the most cost-effective option available to safely meet the recipient's needs in the proposed environment?

_____

_____

_____

7. Has the equipment been tried in the home for fit/safe use? (If no, how was a determination made on the appropriateness of the equipment?):

_____

_____

_____

_____

8. Has the recipient tried this equipment? If no, why not?

_____

_____

_____

_____

9. Additional considerations:

_____

_____

_____

_____

It is the opinion of the following individuals that the requested equipment as stated above is beneficial for the care of this recipient:

_____ _____

Signature of Professional Signature of Recipient/Guardian

_____ _____

Agency / Contact Number Relationship